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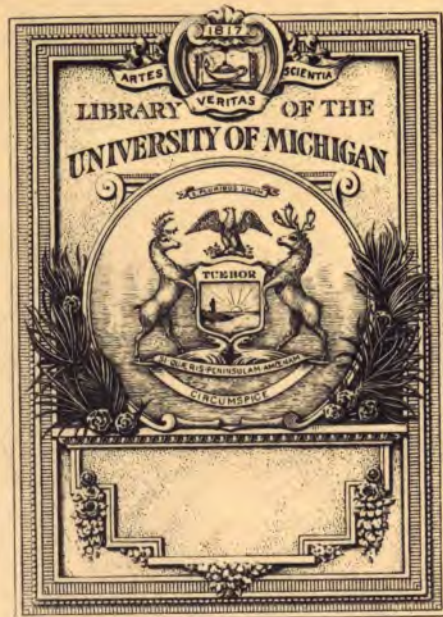
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**A CHILD WELFARE PROBLEM  
THE CARE AND CURE  
OF ENURESIS OR BEDWETTING IN  
CHILD-CARING INSTITUTIONS**

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## PREFACE

It is hoped that this monograph may be found a practical contribution toward the solution of a difficult problem. Criticisms and suggestions are asked from superintendents and physicians of institutions which may be helpful in the preparation of a revised edition. We do not anticipate that this first endeavor in a comparatively unexplored field will be conclusive, but we hope that it may pave the way for a more permanent contribution.

HASTINGS H. HART,  
Director Department of Child-Helping.

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## A Child Welfare Problem

### The Care and Cure of Enuresis or Bedwetting in Child-Caring Institutions

Enuresis nocturna is the medical name for a habit so disagreeable, aggravating, and injurious that matrons and superintendents often say of it: "This is one of the most difficult problems in the institutional care of children." Owing to its nature, matters connected with the habit and its treatment, and the equipment necessary to care for its addicts or victims, are kept in the background in all institutions. The subject is seldom mentioned except among workers and physicians, and by them too often only incidentally, or as required by sanitary and medical necessity. Modern customs of modest expression have also caused a sort of "conspiracy of silence," which has left the matter practically untouched in conventions and publications.

The subject is now considered because a number of advanced child welfare workers feel that the time has come for plain and candid discussion of this distressing and deleterious night practice, so that right principles and methods of relief may be set before hundreds of officers and attendants who are obliged to deal with it day by day. The medical term is used in the title of this brochure to familiarize all with this correct and definite name, to stimulate greater dependence upon the advice of physicians, and to avoid the constant use of the common English expression.

The average child-caring institution usually has a plan for the care and treatment of bedwetters, partly social and partly medical, but nearly always unsystematic. It succeeds in reforming some of the patients and in declaring others incurable; but it generally does not give to the matter the attention it deserves, nor provide separate diagnosis for numerous cases that are alike only in unsanitary exterior manifestations.

If this pamphlet succeeds in setting forth sufficient facts and suggestions to induce a number of institutions to study their cases individually and thoroughly, secure medical and psychological help according to the diagnosis, and apply treatment suited to the varied and more or less serious needs of the afflicted children, it will have accomplished its purpose.

THE STUDY. At the request of the officers of several prominent child-caring institutions who desired special help in the manage-

ment and treatment of their own wards, the Department of Child-Helping of the Russell Sage Foundation recently sent out a questionnaire on this matter to about 300 institutions in all parts of the United States. About 100 answers gave much valuable information and indicated various methods of treatment. It was, however, noteworthy that the writers were practically unanimous in expressing dissatisfaction with the results now obtained in their institutions, and in asking for any new and promising methods and remedies revealed by the inquiry.

The following pages contain a digest of the reports obtained from these child-caring institutions. The facts, methods, treatment, and results have been analyzed and arranged for the information and assistance of others. Perhaps the material will be found as much negative as positive—showing what not to do as well as what is to be done. The study then concludes with some carefully formulated paragraphs on the social management of enuresis cases, co-ordinated with quotations from authorities concerning proper medical diagnosis and treatment.

**NUMBERS AND PERCENTAGES.** To show how serious is the matter under consideration, and the numbers of children actually related to the problem, a simple analysis of a majority of the reports of institutions replying is given. Omitting replies that gave only general information and failed to provide definite figures for tabulation, there remain 78 institutions grouped according to their geographical location, whose population and percentages of children afflicted with enuresis nocturna are as follows:

#### ENURESIS.—NUMBERS AND PERCENTAGES

Sections	No. of In- stitu- tions	Population		Afflicted				Totals		
		Boys	Girls	Boys	Per cent	Girls	Per cent	Popu- lation	Afflicted	
									Total	Per cent
Eastern	29	5,851	3,058	839	14	206	7	8,909	1,045	12
Southern	12	1,445	890	130	9	54	6	2,335	184	8
Middle West	23	4,313	1,594	316	7	90	6	5,907	406	7
Far West	14	982	969	72	7	64	7	1,951	136	7
Total	78	12,591	6,511	1,357	11	414	6	19,102	1,771	9

Several interesting things appear in this table. First, without any effort to secure statistics on a sex basis, it appears that the institutions reporting contain nearly twice as many boys as girls. The United States census of 1910 gave the sex proportions in all child-caring institutions at 54 per cent male and 46 per cent female. Second, this table indicates that the boys are more troubled than girls with this habit or affliction, the boys averaging 11 per cent and the girls 6 per cent. Third, in 78 institutions, scattered all over the Union, and containing over 19,000 inmates, there were about 1,800 children afflicted, or an average of 9 per cent of the whole number. Fourth, these institutions were not in any way "selected"—they were simply the ones that reported statistics; but probably they are in quality and type of inmates about an average of institutions all over the country. Granting that they are average, and estimating about 1,500 institutions for dependents and delinquents in the United States, with an average population of about 145,000, 9 per cent would give over 13,000 habitual bedwetters among the inmates of child-caring institutions. The size and seriousness of the problem to be solved are thus made perfectly plain.

**THE QUESTIONNAIRE.** In the questionnaire inquiries were confined to what was actually being done to overcome the habit. Institution officers were asked to describe the measures taken—medical, dietary, educational, disciplinary, mechanical, and sanitary. They were also asked to add suggestions of their own on additional topics. A somewhat systematic review and analysis of the reports will be profitable.

**MEDICAL MEASURES.** Recognizing the fact that in many cases there is physical debility or disease behind the habit, the first question asked was: Have you ever had a medical examination made of your bedwetters? Note the answers to this query.

Five institutions of the 78 did not answer the question at all, and seven definitely answered "No," making a total of 12 that do not count enuresis a matter for medical treatment at all.

Forty-seven institutions replied simply "Yes," leaving the relative numbers examined unmentioned. One institution said "Once," another "Not lately," still another "Occasionally," one more said "Part of them," one "In some cases," and one "In aggravated cases." A significant reply was this: "We had one of our worst cases examined, and found the child perfectly well."



But eleven institutions, most of them very large and prominent, said: "All of our cases of bedwetting children are carefully examined by regular physicians." This final answer is the one we heartily approve.

The next question was: What treatment was used by your physicians? One institution replied: "The usual medicines and occasionally punishment." Another: "The physicians gave very little help. No medicine given specifically for this habit." A third: "We have had best results from osteopathic treatment." Two others use the same words: "Two of our boys were cured by circumcision." A superintendent of a large industrial school for boys says: "Circumcision has been found efficacious in approximately 80 per cent of the cases." But another superintendent writes: "We had six or eight boys circumcised, with no favorable result in regard to enuresis." Enuresis evidently is due to more than one cause, and no one treatment cures all cases.

Medical treatment is as uncertain of results as is circumcision. Most of the replies say "No results," "Some good results," or "Occasional cures." Many say that the physicians prescribe belladonna. Some use atropine. Still others tell of the use of ergot, cantharis, cystitis tablets, enuresis tablets, nux vomica, hyoscine, potassium bromide, quinine, rhubarb and iron, and various other drugs. This variety in remedies suggests a similar variety in diseases.

Later in this study some definite descriptions and medical suggestions will be quoted; but it should be stated here that no superintendent or other officer of a child-caring institution should order or use any of the above named drugs except after the patient has been carefully examined by a competent physician, and a prescription has been provided under his name and authority. Life and health are too sacred and valuable to be endangered by lay use of elements requiring professional and scientific skill. Have a good doctor prescribe and take the responsibility.

**DIETARY MEASURES.** The institutions were asked: Do you regulate the food of bedwetters or restrict their use of water? Some of the reporting institutions have no rules applying to bedwetters in regard to food and drink. A few others say: "Have tried restrictions, but with little success, as children always manage to evade compliance with such rules." But the great majority of the reports indicate restrictions in both food and

drink the latter part of the day. A few answers will serve to illustrate this entire group:

"Yes; at supper they are given less milk and water; and are allowed no water after supper."

"Same food as others, but last three hours before bedtime water is allowed only sparingly."

"We restrict the use of wet foods and water at and after the evening meal."

"No milk for supper, and no water after 4 p. m., except in very warm weather."

"We allow no candy or other sweets, and very little water after 5 p. m."

"We restrict the use of water and milk at night, and this often effects a cure."

"We regulate by allowing the children to drink freely in the early part of the day, and then permit them to have no milk or water after supper time."

"Bedwetting children should not eat specially stimulating foods at any time, and no sweet stuff in the evening; and their night use of fluids should be systematically limited."

"The supper should be very light, and without soups or sugars; after 5 p. m. no water or other liquids should be allowed. The children may moisten their mouths by holding water in them a moment, or by taking small sips, preferably from spoons, to limit the quantity."

**EDUCATIONAL MEASURES.** These relate to study of the child by institution officers, to ascertaining facts and possible methods of prevention and cure, and to training and education of the child in will and self-control. The first question asked under this head was: Have you ever made a study of the individual bedwetter in order to ascertain: (1) the initial hour at which the child lets water after retiring; (2) the intervals thereafter at which the child repeats the operation?

Some of the institutions have made quite definite investigations along this line. From their statements it appears that there is no fixed or even average time after retiring when the objectionable urinary flow may be expected. Each individual is a law unto himself. Yet the first urination seldom occurs in less than two hours after bedtime. One institution says: "We have some children who have to be called two hours after retiring and so on

all through the night. Others have to be called only once each night." Another excellent institution says: "We had never been able to discover that such children were regular as to time." Still another says: "Some have to be called before 10 p. m., in fact most of them; and they usually wet the bed between 10 and 11 p. m., and between 2 and 3 a. m." A large New York orphanage reports: "Our worst bedwetters sometimes spoil their beds almost immediately after retiring; others for the first time at about 11 p. m., then again three or four hours later. Many of them offend only once, and the majority not more than twice a night."

It is a little disappointing to find that many institutions have never given attention to the periodicity of this habit. Just as people get into the habit of eating three meals a day when two meals would perhaps conserve health and strength equally well, so these other physical habits are fixed into what is called "rhythm" by repetition, and if the "rhythm" can be broken up in enuresis cases, it is much easier to break up the night habit entirely. Dr. Frederic H. Knight, of the New England Home for Little Wanderers, Boston, writes as follows:

"In dealing with enuresis cases we have several modes of treatment. Of course the victory is won when it is possible to break up the rhythm, as we call it. Most of these children under ordinary conditions get into difficulty with surprising regularity. The victory is won when you can succeed in lengthening the time between urinations. . . . If you do not know how long the time is between acts of urination, the night nurse will have to experiment to see how long it is safe to allow the child to remain undisturbed. In a large percentage of children, the unconscious expectation of being aroused before urination occurs tends to lengthen the period of dryness, so that little by little the period between urinations can be lengthened. To lengthen the period the first ten minutes is the most difficult stunt of all. After that patience and perseverance will usually overcome all the difficulties. Whatever is conducive to quiet and restfulness on the part of the child is helpful. No undue excitement of any kind should be indulged in by the child between 4 p. m. and bedtime.

"Now, in trying out this experiment of attempting to break up rhythm—that is, to lengthen the periods between urinations—you will have a percentage of failures, and this percentage of

failures will seem at first to invalidate the whole scheme. But each one of the failures must be dealt with individually. You must make a serious and thoroughgoing attempt to discover some mental or physical cause of enuresis. If one is found, proper treatment plus effort to break up rhythm will in most cases lead to success. . . . Last year we had success in 85 per cent of cases of stubborn enuresis. That is, in children eight, nine, ten, eleven and twelve years of age, and even older; and these results were brought about without surgical interference. This year we shall try lumbar punctures with injections in small quantities of normal salt solution, in order to tone up the part of the nervous system directly concerned."

Dr. Knight's interesting and suggestive scheme is worthy of much thought and attention. In all cases where there is no mental or physical disease, it affords a definite method of procedure; in cases where disease complicates the situation, it can be added to proper medical or surgical treatment with no expense except systematic study and care of the children.

Another educational measure was indicated by the question: What instruction do you give the child as to self-control? In many of the questionnaires no answer is given. In others the institution officers have been candid enough to answer "None." But a number of the more progressive are trying to utilize the power of mind over body to overcome this habit.

A few have discriminatingly answered the question by saying that their appeals, admonitions and instructions have been varied according to the age and mentality of the child. Others have sought to "pound in" their instructions with lurid descriptions of consequences and perhaps threats of penalties. One of the answers is: "We tell them it is a dirty habit, and can be overcome by using their will power." Another says: "We try to arouse them mentally against the habit by giving them private individual talks." Still another remarks: "We try to teach them to exercise self-control, but have no satisfactory results." A Catholic authority says: "We teach the boys that by exercising will power they can do more to stop the habit than anything we can do for them."

This last answer contains an important truth—many of the cases can be cured by mental suggestion self-applied. The human will can be trained to subconscious as well as conscious

action, and the body responds wonderfully to both conscious and subconscious resolutions of the will. Early training by parents and later education by others are effective in many cases in the inhibition of the flow of bodily fluids during the hours of sleep. Motivation is a strong factor. Desire to retain the favor of friends, the danger of loss of good will, the gaining of prizes, the expectation of "dirty work" with soiled garments and bedding, the necessity of overcoming in order to be able to visit nice homes, the disgrace of such a habit as the years of adolescence approach, and many similar matters, may within reasonable limits be used to stimulate the will against the habit.

One more feature of this part of the subject deserves special mention. This inquiry was made: Have you offered a reward as a motive for the child to refrain from bedwetting? Of the 78 institutions whose replies are being specially considered, 31 either left the answer space blank or wrote a plain "No." Of the rest, 33 said simply "Yes," and 14 answered affirmatively and said something about results. From the last group a few answers are quoted. One says: "Yes; rewards help in some cases, in others they seem to have no effect." Another: "No child's name goes on the vacation list until this habit is overcome. Desire for an outing has proved very effective." A third superintendent writes: "We have a room called the clean boys' room, and have made it desirable to sleep there. Many of our boys reform in regard to this habit in order to win a bed in the better room."

Rewards are suited to the age of the child. This reply is from the state of Delaware: "We pay to our little girls a penny a day for spending money. Each time one wets the bed she forfeits five cents. To win even the penny a day many make great efforts to overcome the habit." Another negative sort of reward is in this report from Colorado: "We give a portion of candy to each child every Saturday, but have a rule that none shall be given to bedwetters." A German institution reports: "We offer as a special reward for breaking the habit privileges of visiting at home, and other prized advantages." A number of institutions say substantially: "Yes, we offer rewards, and obtain good results." A few say: "We give rewards, and have noted a few temporary but not many permanent good results." This detailed consideration of the use and results of rewards is given

because of its importance from a psychological standpoint. No doubt exists of the value of a reasonable use of this stimulus. Like other measures here noted, however, it is but one course of action out of many to be adopted in overcoming enuresis.

It is a general observation of institutions everywhere that normal children develop a special desire to overcome this habit as they approach adolescence. In fact, the greater number of healthy children addicted to bedwetting break the habit at from twelve to fifteen years of age. There are special reasons for this. First, the physical changes of this period no doubt aid in winning freedom. Secondly, the developing social nature, with its requirements in regard to association, make the habit practically unbearable, and lead to the use of all known means to avoid offending. Thirdly, the enlarging mental vision of the child, showing the habit in all its disagreeable and injurious relations, leads to intense use of the will in inhibition.

In many instances institution workers have been able to trace this habit, or rather its causes, back to the parents of the children. There is no question that lack of parental care and training accounts for hundreds of cases. The parents were themselves coarse, filthy, careless, and ignorant; and the children were never taught or trained in the decencies and proprieties of life. When they are taken into a clean institution they must be taught for the first time what they should have been taught in babyhood. The response is often gratifying, and many of the children soon become as cleanly in this respect as those reared in first-class homes. It is when disease complicates the situation that overcoming the habit is most difficult. Whether or not in some cases children inherit physical weaknesses and predisposition to enuresis, seems not to have been definitely studied up to this time; but it is reasonable to conclude that such is the fact, and that it makes wise and careful treatment of afflicted children even more imperative.

**DISCIPLINARY MEASURES.** The disciplinary measures used for the correction of this habit may be divided into four groups—(a) corporal punishment; (b) shame and disgrace; (c) deprivations; (d) disagreeable tasks and duties, especially such as are related to soiled garments and bedding. These will be given separate mention.

(a) Corporal punishment is occasionally used by some institutions, but is entirely rejected by others. One report says: "We have used corporal punishment in a few cases but without permanent results." The officers of a large Jewish orphanage say: "Yes, we have used corporal punishment, and it has sometimes been successful." Another institution declares: "We have used corporal punishment, but the effect lasted only a few nights." Still another says: "We have used but have had no satisfactory results from corporal punishment." A Connecticut superintendent writes: "Corporal punishment is used after all other measures fail. In most cases it works well if the spanking is given every time the offense is committed."

On the other side are very positive convictions that any resort to corporal punishment for the correction of this habit is unwarranted. Many questionnaires record in answer to the query as to its use an emphatic "No." One says: "Not now; we did in one case, and afterward found out that the child's father was also an habitual bedwetter." Another replies: "Not of late years. Formerly corporal punishment was used in some cases with good results, although we now believe equally good results might have been secured by the use of other means." One of the largest orphanages in New York City declares: "We do not employ corporal punishment in any enuresis cases."

Our conclusions in regard to this method of controlling enuresis may be briefly and emphatically summed up. While it is realized that there may be cases where wilful and defiant or morose and sullen children persistently refuse to co-operate with attendants and nurses to correct this trouble, and while it is possible that some such cases might be improved by the judicious use of a reasonable amount of corporal punishment, the liability to the abuse of this method by ignorant or injudicious people is so great, and the danger of doing injustice to afflicted children who are not to blame for their unfortunate condition is so serious, that we are unwilling to give any endorsement to the use of corporal punishment as a remedy for this evil. We believe that in every case, by the exercise of patience and wisdom, an effective substitute may be found.

Most people apply the term corporal punishment only to the use of the whip, strap, or ruler, forgetting that any physical distress imposed upon a child as punishment is as truly "corporal"

as blows upon the body. Any physical punishment, but especially the use of whipping, to forcibly compel the change of a habit like bedwetting, so often due to ignorance, to inherited weakness and predisposition, and to serious disease, is almost a crime against childhood. The institution's first duty is positively and accurately to diagnose the cause of the trouble. Then it must give kindly and sympathetic instruction to remove all ignorance and misconception, provide needed remedies and physical equipment, stimulate the child's will, help it to create new purposes, and develop a strong desire to be free from the depressing habit. In other words, right treatment calls for constructive rather than destructive measures, in order to overcome the enuresis and develop the child.

(b) The endeavor to shame a child into special care and effort to avoid bedwetting, while proper within certain limits, is also liable to abuse and to become a cruelty equal to unwarranted corporal punishment. One very prominent child welfare worker says: "We prefer to encourage the children to overcome by striving for honors, rather than to specially reproach them for personal failures." Another writes: "We have tried shaming the children and sometimes have secured good results." A discriminating reply says: "Shame has succeeded in reforming some of the older offenders; it is not effective with the smaller children." One institution has this plan: "We assign those with this habit to bedwetters' sleeping quarters, which is in a sense a disgrace; but it has not resulted in reducing to any extent the number of bedwetters."

A Jewish superintendent writes: "Shaming, to have effect, must be more or less public, and in my judgment seldom accomplishes any permanent good results. On the contrary, it may tend to make the child a hero and a martyr among its fellows, and thus do more harm than good." A Missouri matron says: "A child whose training has been neglected is difficult to reach successfully by shame; and well reared children are always so ashamed of the habit that shaming by us is unnecessary and cruel." From Michigan comes this suggestion: "Generally the habit is quite beyond the child's control, and to punish by shaming is cruel. Teaching, training, offer of rewards, stimulation of the will, with medical attention when needed, are much more likely to secure satisfactory results."



It is true that a certain odium and disgrace is inevitably incurred through this unfortunate habit or condition, even in cases where the child is helpless and entirely free from blame. This fact should be privately and sympathetically explained to subjects old enough to understand it, as one reason for strong efforts to overcome enuresis; but in no case should a child be held up to public odium and contumely. Nor should the enuresis victim be subjected to contempt, mockery and ridicule from the other children, who should be carefully instructed as to the wrong and unkindness of such actions. Institution officers must control these matters. A sensitive child may receive life-long injury from the shame and ridicule showered upon him for what our best physicians declare is in "perhaps a majority of cases . . . entirely beyond his control."

(c) To deprive a bedwetting child of various desired foods, privileges, associations, entertainments, little luxuries, special clothing, vacation outings, and the like, is a method frequently resorted to by the institution officials. It is the negative form of action that on its positive side gives rewards for overcoming the habit. Within limits, and wisely used, it is a form of discipline allowable and salutary. Probably its principal effect is in stimulation of the will.

A few quotations will sufficiently illustrate this practice and its results. A matron of a masonic orphanage says: "In our institution all matters of discipline come before our boys and girls assembly. Demerit marks that must be accounted for are given to bedwetters." A Colorado institution reports: "We have deportment records, a sheet being sent from each department to the superintendent every morning. Bedwetting automatically 'fines' each offender and the proper amount is deducted on the deportment records." Another says: "We find it helpful to take away from bedwetters the privilege of playing with other children." A California superintendent writes: "We sometimes deprive bedwetters of desserts, or place older children at the baby table for meals." From Pennsylvania comes this suggestion: "We often deprive wilful bedwetters of pleasures and privileges; but lest we do any an injustice, we always make sure the fault is due to neglect or carelessness, and not to disease or ignorance."

(d) To compel average habitual bedwetters to attend to their own soiled garments and malodorous bedding is a common prac-

tice in institutions all over the United States. We see no reason to object to this, if the child is physically able and mentally competent to perform the task.

It sometimes happens that because enuresis victims are thus related to disagreeable matters, unwise or conscienceless institution attendants impose upon them, and compel them to perform, other tasks connected with dormitory and lavatory work that properly belong to others. Such extension of unpleasant and disagreeable work is both unwise and unjust. As already shown, not all who are addicted to bedwetting are blameworthy, and even the worst of coarse and careless offenders have rights that attendants ought to respect.

The methods and practice of various institutions are illustrated by a few quotations from the reports. A Connecticut matron writes: "We always make our bedwetters wash their soiled garments and bedding before the articles are sent to the laundry." A Philadelphia superintendent says: "We have each bedwetter wash his or her soiled garments and bedding daily, or as often as the lapse occurs. They take the articles to the laundry in the intervals between or after working hours, to avoid hindering regular work and to escape observation." The following report from the state of Washington covers several points: "We have had very little trouble in breaking up the habit. We never shame the girls but treat the trouble as a misfortune. We do not allow other girls to mention the matter to those afflicted. Doing their own washing every morning attracts enough attention. They wash out their own gowns, sheets and blankets every day, and have everything fresh and clean each night." A Nebraska worker says: "The only disagreeable task put upon our bedwetters is to compel them to clean up after themselves." An Indiana superintendent reports: "All of our bedwetting children who are old enough wash out their own gowns and bedding. This is hardly in the nature of a punishment, but is only fair to the matron and others. We do not try to make the bedwetters conspicuous at this work."

**MECHANICAL MEASURES.** There are several types of mechanical measures in use, but while some may be helpful in special cases, it is not likely that any child addicted to enuresis was ever cured by them. A very prominent Boston institution reports: "We have abandoned all such methods, believing mere mechani-

cal measures of no special use in enuresis cases." Another high grade institution in Ohio says: "One of the important things to do is to make the child as comfortable as possible. That to a very great extent prevents restlessness, and a half-wakeful state with physical discomfort aggravates the trouble. Mechanical appliances usually prevent comfortable sleep, and do more to make trouble than to prevent it."

Nevertheless, a few suggestions on this line are necessary, for some methods used by progressive workers are not open to the objections made in the preceding paragraph.

It is held by some physicians that small pillows, none at all, or even elevating the foot of the bed from two to four inches, will aid the sleeper in avoiding enuresis. An orphanage in New Orleans reports: "At our physician's suggestion we have tried lifting the foot of the bed, so as to keep the upper part of the body low." Another says: "We have taken the pillows off the beds. I doubt if it helps much." Still another: "Our doctor told us to set the foot of the bed four inches higher than the head, but it did not seem to do any good."

It is claimed with some reason that the lapses occur mainly when children are sleeping on their backs. Appliances to compel sleeping on the side are frequently used. A Washington, D. C., superintendent writes: "At the suggestion of our doctor we have tied something hard, an empty spool, for instance, on the child's back so that it would prove uncomfortable unless the child slept on its side." Another says: "By order of our doctor we have attached a small cigar box to the back of the bedwetting child, to compel sleeping on the side." Still another: "We have placed rolls of crinkly paper beside the offending children to waken them if they turn over on their backs in their sleep."

The practical and generally necessary plan of an enforced awakening one or more times during the night, to discharge the contents of the bladder, is in operation in most institutions. Night nurses and watchmen are instructed to waken the children at definite times. As Dr. Knight showed in his statements on "rhythm," quoted in the section on educational measures, the nurse or watchman can render special service by a study of individual cases, and by efforts to prolong the periods between urinations.

The practice of various institutions is best illustrated by direct

quotations from their replies to the questionnaire. A New Jersey report says: "Our night watch calls up the girls at 10 p. m., 2 a. m. and 5 a. m. in bad cases. Others are called only once or twice a night." A New York superintendent writes: "We call most of our bedwetters three times a night. If the children are not called up one or two hours after retiring, we often find wet beds. Another dangerous time is about four o'clock in the morning." Another says: "We call our bedwetters up once or twice a night as may be necessary. We insist on children's going to the toilet before retiring, then the night watch wakens them two or three hours later, and in bad cases early in the morning. Many children form the habit of waking themselves at a certain time, and we find it a great help."

An Ohio superintendent writes: "On the average bedwetters are called up twice each night, the time being fixed by a careful study of the habits in each case." A Delaware worker says: "We have the children who require it taken up two or three times a night. The majority of cases are cured after a time." A Pennsylvania institution declares: "To awaken the children at intervals during the night is the only efficient plan so far found. The attendant by careful attention to each case is able to forecast the intervals of safety and the times when each one must be awakened." A small orphanage reports: "We have no special night nurse. The caretakers sleep in rooms adjoining the dormitories with doors open between. They are required to look after the children so afflicted, and get them up as often as is necessary." A Boston superintendent says: "Our system of awakening bed-wetting children includes such study of each case as will enable the nurse to leave the child undisturbed as long as possible, and to seek to diminish gradually the number of calls each night. Generally by careful work the periods are lengthened until the whole night is passed without enuresis trouble."

**SANITARY MEASURES.** In all institutions there are more or less complete systems in operation to provide humane and comfortable sleeping quarters for those addicted to bedwetting, and at the same time to give as little offense as possible to other inmates and the officers. As already noted, some institutions provide separate rooms or dormitories, and all provide special garments and bedding, with extra lavatory and laundry facilities, according to the numbers and seriousness of the cases in care.

With night watchmen or nurses on duty, and the bedwetters called up periodically as required, it will generally be unnecessary to have enuresis cases sleep in separate rooms or dormitories, thus emphasizing their condition and making a sort of pariah class of them. The mental disturbance caused by being set apart on account of the habit, and the discouragement incident to such treatment, will probably neutralize efforts to cure the children, and fix the habit upon them much longer than is necessary. We therefore deprecate such separation, unless in extreme cases, and advocate that enuresis cases be treated in all general matters as nearly like all other children in the institutions as possible.

The provision of special beds and bedding for bad and persistent cases is another matter. It has been suggested that the mental stimulus of having a bed just like others is a strong aid in overcoming the habit. A boy who will carelessly soil old blankets or an ill-smelling mattress will generally do his utmost to avoid spoiling a nice bed. It pays sometimes to have a few nice beds inadvertently spoiled for the sake of utilizing this psychological fact in the treatment of these cases.

But many children must be provided with special clothing and bed equipment. A New York institution reports: "We use ordinary woven wire spring beds for our enuresis cases, with blankets that can be frequently washed instead of mattresses, and these protected with rubber sheets. The regular sheets are placed above the rubber ones, and the children's nightgowns are changed and laundered daily." Another says: "Our bedwetters sleep in ordinary beds, with the mattresses protected with rubber sheets, which in varying widths costs from ninety cents to \$1.50 per yard."

One large institution says: "We use ordinary nightgowns and sheets for these children, but place waterproof blankets under the sheets. The gowns and sheets are laundered daily." Another states: "For these cases we use no mattresses, but thick washable pads and folded blankets, protected with rubber sheeting. The rest of the bedding and the children's gowns are the same as other children have." A Delaware worker says: "We use a firm woven wire spring bed and a straw mattress, with a rubber sheet for protection." A Connecticut institution reports: "For our bedwetters we use a regular hospital bed with national

spring, excelsior mattresses with cotton top, blankets and rubber sheeting. Nightgowns, bed linen and blankets are washed daily." A Missouri matron says: "We have a special washable pad to cover the rubber sheet. All linens and gowns are washed daily. The rubber sheets are rendered sanitary by sponging them off with a five per cent solution of carbolic acid and hanging them in the open air for several hours each day."

Many institutions in the middle and far west use straw beds for bedwetting children. From Nebraska comes this statement: "We find straw ticks better than mattresses for this class of children. The ticks are more sanitary for they can be emptied, washed, and refilled whenever it is necessary; and as beds they are very comfortable. We formerly used oilcloth protectors, but discontinued the practice because we consider the use of waterproof materials unsanitary." Another midwestern institution says: "We use rubber sheets over straw ticks or mattresses; and as soon as the ticks are soiled and malodorous, we empty them and burn the straw." An Ohio report mentions another material: "We use ordinary beds with good wire springs, on which we put husk mattresses that can be changed at small cost when necessary, and also use the best double-faced rubber sheeting."

Passing now from sanitary equipment to sanitary methods of personal treatment, the matter of baths naturally stands out prominently. It may be possible for some children to get along with one or two baths a week, but the most unprogressive institution worker would hardly want to live in the same house with a chronic bedwetter whose body was cleansed only on Saturday afternoons. Common decency demands frequent baths for enuresis cases. Most institutions of the better class give all bedwetters daily baths; in fact, it is becoming common for all institutional children to have a daily tub or shower. One institution replying to the questionnaire mentions the fact that every bedwetting child must have a thorough bath in the morning before going out among its fellows. It is a matter too often neglected, carelessly overlooked, or superficially done, but relates to the health of the child, the sanitation of the institution, and the personal comfort of all who must be near the bedwetter during the day.

In this connection the questionnaire brought an extremely

suggestive statement from a Delaware superintendent. It is presented as a trained worker's contribution to methods of cure for enuresis: "My one and only, and I may say sure, plan is this—I give the bedwetting child frequent cold water baths. This is my method. The girl sits on the edge of the bath-tub, and I pour slowly about two or three quarts of cold water down her spine. Starting and stopping, then start again. After the water has been thus poured, a brisk towel rub for several minutes is given. This is all that I do in the way of remedy—stimulate the spine. And I have never failed in one case. This process must be kept up for a long while, probably six months or a year. Nor should it cease with the stopping of the bedwetting. Continue it for six months after the last lapse. The method is harmless, easily administered, and I have found it effectual."

**SPECIAL STUDY OF ENURESIS.** So far in this study we have examined our subject almost wholly from the social standpoint, with special reference to the experience of institutional officers and employes, as revealed by the questionnaire. Before leaving the subject it is best to note a few statements of good medical authorities and then draw some conclusions from what has been learned.

Superintendent J. F. Brown, of Wisconsin, says: "Successful treatment of enuresis depends upon discovering the cause. Every organ and reflex must be carefully studied. We must also look for phimosis, pinworms, enlarged tonsils, adenoids, and so forth. Proper diet, hygiene, habit, and training are the elements of success in treatment, and even then we often meet cases that can not be controlled."

Dr. Thompson S. Westcott, an eminent authority, makes this statement concerning enuresis nocturna: "This distressing and often tedious condition is either due to weakness of the bladder itself or is a symptom of a general neurosis, particularly hysteria, which is so common in children. In the latter case the enuresis is usually nocturnal. In many children the cause of enuresis is found in weakness of the sphincters, the sphincter vesicæ, and the compressor urethræ. In many cases other etiologic factors are present, such as heredity, anemia, psychic excitement, especially during the school-going age, false modesty, and bodily weakness after some severe illness, particularly an infectious disease, and possibly after exposure to cold. Enuresis may also

be a reflex symptom due to various conditions, such as rhagades or fissures of the rectum, intestinal parasites (*oxyuris vermicularis*, *ascarides*), diseases of the genital organs, as phimosis, balanitis, or vulvovaginitis; or the condition may occur in association with renal and vesical calculi or cystitis. In a number of cases interference with nasal respiration by adenoid vegetations has not without reason been given as the cause of nocturnal enuresis.”\*

Under the topic Incontinence of Urine, Drs. White and Martin say: “Incontinence of children is essentially a functional disease. It usually begins about the fourth or fifth year, but sometimes is continued from early infancy. There is a natural tendency toward cure at the period of puberty, but many cases persist beyond this time. It is almost invariably nocturnal. Exceptionally it is both nocturnal and diurnal. The cause of this incontinence is unknown. Heredity is a distinctly predisposing factor. The possibility of epilepsy as an etiological factor should always be carefully considered. . . . Before deciding that a child who wets his bed at night or soils his clothing in the day time is suffering from a purely functional trouble, diabetes, polyuria, vesical tuberculosis, cystitis, nephritis, calculus and foreign body must be eliminated. The anus and the rectum should be examined for polyp, eczema, or seatworms. The urethra should be explored for narrowings or valvular formations, and, since most children are phimotic, it is well on general principles to practise circumcision. This in itself is often curative. Errors of diet must be carefully corrected, and the urine rendered bland by giving water and milk in abundance. Liquids should not, however, be given in the evening.”†

The general treatment for cases not due to definite disease is outlined by Drs. White and Martin, and indicates the professional source of some of the methods in use in various institutions: “It sometimes happens that a habit of nocturnal incontinence is due originally to carelessness. . . . It will be found that the urine is passed at about the same hour every night. If the nurse is directed to inspect the child hourly for two or three

\* Reference Handbook of the Diseases of Children, p. 143. Edited by Thompson S. Westcott, M.D. Philadelphia, W. B. Saunders and Co., 1906.

† White and Martin: Genito-Urinary Surgery and Venereal Diseases, pp. 593-594. Philadelphia, J. B. Lippincott Co., 1898.



nights, the time of semi-conscious urination may be determined. In these cases a cure may be accomplished by having the child waked at about one or two in the morning, or an hour before his habitual time of involuntary micturition, and made to empty his bladder. This treatment may be re-enforced by a system of rewards and punishment. The child should never be severely disciplined, since in perhaps a majority of cases the disturbance of function is entirely beyond his control. As further means of lessening the tendency to nocturnal enuresis, the application of a bandage about the waist of the child, with a projection in the back so that he is compelled to lie on his side, sleeping on a comparatively hard bed with covering just sufficient for necessary warmth, the elevation of the foot of the bed, and counter-irritation in the form of blisters over the lumbar spine, have been tried with apparently satisfactory results."\*

One reason for these quotations is to convince everybody that enuresis is primarily a medical problem, possibly involving one or several very serious diseases. The fact that over 15 per cent of the institutions replying to the questionnaire ignored the medical aspects of their work with enuresis cases is sufficient proof that such an authoritative description is needed. Another reason is the hope that a full statement of the relations of enuresis to disease may lead many institutions, where the medical examination and treatment of bedwetters have heretofore been careless and perfunctory, to note the more serious phases of the problem, and be truly thorough in their work.

It is also plainly evident from the foregoing that there can be no one medical prescription or course of treatment suited to all cases of enuresis. Any one of a dozen diseases or unsound physical conditions may cause the weakness or disturbance resulting in bedwetting; and for each variant in cause there must be a corresponding change in drug medication or other treatment. Therefore no drug prescriptions are here given. Institution officers are urged to seek competent medical advice, and, when careful diagnosis has indicated medication or treatment, to carry out the physician's instructions to the very letter.

**THREE CAUSES OF ENURESIS.** As already shown, there are many conditions that combined or separately will produce the bedwetting habit; but there are three special causes of enuresis

\* Genito-Urinary Surgery, previously cited, p. 595.

that should have extraordinary attention from the officers and physicians of child-caring institutions.

**1. Feeble-mindedness.** It has been the experience of many child welfare workers that bedwetting is a habit especially common among children who are mentally subnormal. They usually lack not only mental power but also sensitiveness, and the ability to acquire correct ideas and habits along the lines of social custom and propriety. Often feeble-minded children expose their persons freely, speak of the calls of nature and similar matters without reserve, and to many of them shame and modesty are unknown qualities. Even when they enter the teens, and on up to maturity of years, they remain little children, incompetent and irresponsible, constitutionally unable to advance to higher attainments. It should also be noted that very frequently, as Dr. Cornell has pointed out: "The poorly formed brain is paralleled by numerous defects of other organs of the body." No wonder then that among such children the uncleanly enuresis habit is the rule rather than the exception, as is found to be true wherever psychological examinations have been specially used in the study of institutional populations. The fact that feeble-mindedness is thus closely associated with enuresis is another reason for the immediate diagnosis of every case on its arrival at the institution by competent physicians and psychologists in order that the treatment may be adapted to the child's mentality.

**2. Epilepsy.** In the quotation from Genito-Urinary Surgery, given in a preceding paragraph, are these words: "The possibility of epilepsy as an etiological factor should always be carefully considered." It is a quite common belief among laymen that all epileptics are subject to the "falling sickness," that is, to recurring attacks of convulsive fits that render them helpless. Late researches prove that there are many afflicted with epilepsy who do not manifest the disease in this manner. Its effects are seen rather in erratic emotions and mental action, and in physical inaptitudes, weaknesses, and abnormalities. Many bedwetters are undoubtedly the victims of this serious and mysterious disease, and should be constantly under the care of competent physicians, and not be left to the careless and sometimes ungentle handling of unskilled caretakers. Again we insist that careful diagnosis is the first essential of treatment of enuresis cases in child-caring institutions. We believe that epileptic bedwetters

will be found to compose a larger fraction of enuresis patients than has heretofore been supposed.

**3. Masturbation.** There is no doubt that this evil practice, known to have been begun by children of both sexes when they were but six or eight years old, or even younger, is the predisposing cause of many cases of enuresis. First, the practice tends to destroy the finer nature and sensibilities, lowers the moral tone and conceptions, makes the child sneaking, deceptive, and vulgar, depletes the physical vigor, creates lassitude and laziness, and thus prepares the way for neglect of nature's calls and incontinence of urine. Second, the practice causes a special strain upon the genital organs, weakens the nerves and muscles in the adjacent parts, and in many cases leads to at least partial loss of control of the flow of urine even in day time. No wonder that the combined mental and physical depression due to this practice leads to the most excessive, continuous, and incurable cases of enuresis to be found anywhere. Here the physicians and nurses must unite with the institution officers and caretakers in a joint medical and social treatment of the victim, as the only hope of controlling the practice and overcoming the habit.

**BEDWETTERS IN FOSTER HOMES.** Children from child-placing agencies and child-caring institutions pass by thousands every year into foster homes, either as boarders or as free members of the families, or as paid workers with home privileges. Among these are hundreds who have been bedwetters and have been pronounced cured, and some who are still more or less addicted to the habit. Those supposed to be cured frequently relapse under the different conditions and less rigorous discipline of life in a private family. The trouble, embarrassment, and even friction caused by this condition or development are too well known to require special description. In reference to this matter the following suggestions are offered:

1. As a matter of right and courtesy, the agencies and institutions placing out children who have been or still are bedwetters, owe to foster families a candid statement of the facts, so that proper precautions may be taken, helpful and sympathetic relations be established for the child, and when necessary provisions be made for special or continued treatment for the trouble.

2. The burden of expense and treatment of placed-out children in many cases should be borne or shared by the responsible

agency or institution, especially in cases requiring medical or psychological advice. It is often possible for the organization to enlist the interest and aid of good local physicians, who will treat such children for a merely nominal compensation.

3. Many of the methods of care and forms of treatment mentioned or recommended in the preceding pages for children in institutional care apply equally well to children in private families, and can be used to large extent by intelligent people in ordinary homes. This is especially true of matters relating to diet and the limitation of liquids the latter part of the day; and many suggestions in the section on educational measures are as good for the private home as for the large institution. The ideas and principles in regard to disciplinary measures are not limited to orphanages or reformatories, but apply as truly anywhere; and there are many hints in regard to general conditions and physical equipment that are valuable to any home where there is a victim of enuresis. Therefore, parents and foster parents may study all of the preceding pages with profit, if a child in the home is afflicted with this unfortunate, disagreeable, and seriously injurious habit. Especially would we emphasize the necessity in all cases of having competent physicians make thorough examinations of the children, so that wise and suitable measures may be taken to cure the predisposing disease and to overcome the enuresis.

**DUTIES AND METHODS SUMMARIZED.** In the light of what has been learned, several important duties and methods may be impressed upon the minds of institutional managers and workers, in order to improve the treatment accorded to the enuresis cases in their care.

1. The first thing to be done is to secure a careful diagnosis of each case as it appears. This should include the social, historical, and personal study of the child, and a thorough physical examination by a competent physician. In some cases involving nerve or brain trouble the expert aid of psychologists or psychiatrists may be necessary.

2. Treatment of each case must be based upon what is disclosed by the diagnosis. Types of treatment will be indicated according as the diagnosis reveals as predominant any one of four principal causes:

(a) Inherited disease or predisposition to enuresis.

- (b) Acquired or developed disease, mental or physical.
- (c) Bad or imperfect early training or parental indifference.
- (d) Personal ignorance, carelessness, or indifference of the child.

3. Medical treatment should never be attempted except under the direct instruction of a competent physician. When the diagnosis discloses mental deficiency or disease, the services of expert psychologists and psychiatrists should be obtained.

4. Circumcision and other surgical operations should be sparingly resorted to, and only when proper diagnosis has shown them to be necessary.

5. Careful regulation of diet and the limitation of the use of fluids the latter part of each day, are excellent aids in overcoming the habit.

6. Corporal punishment is a doubtful method for the correction of any juvenile offense, and should be used sparingly even by parents. Because it is so seldom justifiable, and so liable to abuse in institutions, it should never be employed, at least in the form of whipping or other means for the infliction of bodily pain, to compel children to avoid bedwetting.

7. Special results may be expected in many cases from proper instruction, stimulation of the will, and the use of strong and varied motivation.

8. The wise use of rewards and deprivations is a proper form of will stimulus and motivation.

9. To subject a bedwetting child to public reproach and disgrace, or allow other children to mock and ridicule enuresis victims, is wrong and reprehensible.

10. Mechanical means of combatting the habit must be fitted to the individual cases under expert advice. Probably no two children will require or respond equally to the same environmental stimulus. The use of appliances to prevent sleeping on the back, of beds elevated at the foot, of cold baths, and similar devices should be directed always by some one skilled and responsible, and not be left to ordinary attendants or untrained institution help.

11. If possible, enuresis cases should be kept in close day and night association with normal children. The use of separate dormitories should not be resorted to except in extreme cases. There will be a special stimulus to refrain from wetting the bed

if it is a nice one and located near those of other children not troubled with enuresis. In a separate dormitory, to which the habit has driven the child, there is a letting down of will from that very fact. The child consciously or unconsciously will say: "If I offend here it will not matter much." And in a sensitive child the separation causes a nervous depression that makes reformation more difficult.

12. The use of special sanitary night clothing and bedding is a necessity. Many institutions confess to the use of "old mattresses and blankets" and in other ways deprive the enuresis sufferers of night comforts. This treatment in itself aids in the perpetuation of the trouble. Money spent for suitable equipment is well and wisely used.

13. The average institution is inadequately supplied with bathing facilities, and the average worker is not fully awake in regard to the benefits the children derive from frequent baths. This is especially true in regard to enuresis cases. The writer has known institutions where the institutional group received a "tubbing" only on Saturday; and the bedwetters received no more attention of this kind than the rest of the children. The malodorous result may be imagined. Every bedwetter should have a full bath every morning, as well as other baths as occasion may demand.

14. The practice of requiring the children to care for their own night clothing and bedding, and giving the soiled articles preliminary washing before they go to the regular laundry, is proper, and desirable, if the children are physically able and mentally competent, but it should be done without undue publicity, or the exposure of the children to the scoffs and ridicule of their fellows.

15. All soiled clothes and bedding should be cleansed and renovated daily. No child should be compelled to use a gown or bed soaked the previous night and left uncleansed, even if dried out during the day. Extra laundry bills will be more than made up by the helpful psychological effect of a clean bed every night. Open windows and all possible sunlight in the dormitory also aid in comfort and sanitation.

16. The use of night nurses and intelligent watchmen, to study the night habits of enuresis cases, waken the children and get them up at suitable hours, and influence the children helpfully

